City of Scottsdale Health Tradition Medical Plan, Administered by MMSI, Claim Form

PROCEDURE FOR FILING A CLAIM

All Claims

1. Complete Part 1 of the form, please answer all questions.
2. Have Part 2 (see back of form) completed by the Physician or Supplier, attach all bills securely, and forward to the address below.

PART1 — MUST BE COMPLETED BY EMPLOYEE

1. EMPLOYEE NAME (PRINT) LAST / FIRST / MIDDLE	2. BIRTH DATE MO. DA. YR.	SEX ☐ M ☐ F	3. MMSI IDENTIFICATION #

4. ADDRESS / CITY / STATE / ZIP	5. TELEPHONE NO.

6. PATIENT NAME	7. RELATIONSHIP TO EMPLOYEE	8. PATIENT BIRTH DATE	9. IS PATIENT F/T STUDENT ☐ YES ☐ NO NAME OF SCHOOL CREDIT HOURS

10. SPOUSE'S NAME	11. SPOUSE'S BIRTH DATE	11A. SPOUSE'S SOC. SEC. NO.

12. SPOUSE'S EMPLOYER NAME AND ADDRESS 13. CITY / STATE / ZIP	14. DOES PATIENT HAVE OTHER COVERAGE? ☐ YES ☐ NO IF YES, CO. NAME ADDRESS POLICY NO.

15. DOES SPOUSE HAVE OTHER COVERAGE? ☐ YES ☐ NO	16. DID INJURY OCCUR WHILE ON THE JOB? ☐ YES ☐ NO	17. IS CLAIM A RESULT OF ☐ ILLNESS ☐ ACCIDENT	18. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED MO. DA. YR.	19. IS THERE OTHER COVERAGE FOR THIS ACCIDENT? ☐ YES ☐ NO

20. HOW AND WHERE DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?	21. HAVE YOU FILED FOR WORKER'S COMPENSATION FOR THIS CONDITION? ☐ YES ☐ NO

22. AUTHORIZATION TO RELEASE INFORMATION	23. AUTHORIZATION TO PAY BENEFITS PROVIDER
I HEREBY AUTHORIZE THE HEREIN SIGNED PROVIDER TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I ALSO CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE.	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER FOR HIS/HER SERVICES AS DESCRIBED HEREIN NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGES FOR THOSE SERVICES. I ALSO CERTIFY THAT THE ABOVE INFORMATION IS TRUE ACCURATE AND COMPLETE.
PATIENT OR PARENT - GUARDIAN IF MINOR — DATE	PATIENT OR PARENT - GUARDIAN IF MINOR — DATE

Send to: MMSI Health Tradition Health Plan
4001 41st Street NW, Rochester, MN 55901-8901

MMSI Customer Service
(866) 206-5724

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PART 2	TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

1. DATE OF ILLNESS (FIRST SYMPTOM OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	2. DATE FIRST CONSULTED YOU FOR THIS CONDITION
3. IF PATIENT HAS HAD SIMILAR ILLNESS OR INJURY, GIVE DATES	4. IF AN EMERGENCY, CHECK HERE

5. DATE PATIENT ABLE TO RETURN TO WORK	6. DATE OF TOTAL DISABILITY FROM THROUGH	7. DATE OF PARTIAL DISABILITY FROM THROUGH

8. NAME OF REFERRING PHYSICIAN (E.G. PUBLIC HEALTH AGENCY)	9. FOR SERVICES RELATED TO HOSPITALIZATION DATES ADMITTED DISCHARGED

10. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (PLEASE INDICATE PRIMARY AND SECONDARY)

1.

2.

3.

4.

12. PROCEDURES, MEDICAL SERVICES, SUPPLIES FURNISHED

DATES OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE	DESCRIPTION OF SERVICES	TYPE OF SERVICE	CHARGES	DAYS OR UNITS	DIAGNOSTIC CODE

13. PHYSCIAN'S NAME AND ADDRESS (INCLUDE ZIP CODE)	14. TELEPHONE NUMBER	15. ENTER TAXPAYER IDENTIFICATION NUMBER TO BE USED FOR 1099 REPORTING PURPOSES, REQUIRED BY LAW

16. PATIENT ACCOUNT NUMBER	17. TOTAL CHARGE	18. AMOUNT PAID	19. BALANCE DUE

20. PHYSICIAN'S OR SUPPLIER'S SIGNATURE	21. DATE